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Decolonizing medical education: an analysis of the 2014 National Curriculum Guidelines

Decolonizando a formação médica: análise das Diretrizes Curriculares Nacionais de 2014

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ABSTRACT

Introduction: The 2014 National Curriculum Guidelines (NCG) for medical courses regulate medical education in Brazil and introduce a perspective that integrates the biological aspects and social determinants of health into the teaching process.

Objective: This study aimed to critically analyze the NCG from the perspective of decolonial theory, as discussed by Quijano, Mignolo, and Santos.

Method: A critical documentary analysis, conducted using a qualitative and interpretative approach, examined the 2014 NGC for medical courses from a decolonial theory perspective.

Results: Although the NCG seeks to promote diversity and inclusion, it remains limited by a predominantly Eurocentric epistemological knowledge and may allow alternative epistemologies.

Conclusion: The decolonization of medical education aims to transform the education of health professionals, enabling them to engage critically and ethically within a society marked by cultural diversity. While the NCG represents a relevant progress, a comprehensive revision is needed to reflect local realities and reduce the dependence on Eurocentric knowledge rooted in power structures that perpetuate exclusion and inequality in medical education.

Keywords: National Curriculum Guidelines; Medical Education; Decolonial Education.

RESUMO

Introdução: *As Diretrizes Curriculares Nacionais (DCN) de 2014 para os cursos de Medicina representam a normatização na formação dos profissionais no Brasil. O documento prevê uma nova perspectiva na formação médica que alinhe os aspectos biológicos e determinantes sociais da saúde, juntamente com o processo de ensino.*

Objetivo: *Este estudo propõe uma análise crítica das diretrizes sob a perspectiva da teoria decolonial, conforme discutida por autores como Quijano, Mignolo e Santos.*

Método: *Trata-se de uma análise documental crítica das DCN de 2014 para os cursos de Medicina, na perspectiva da teoria decolonial. A pesquisa adota uma abordagem qualitativa e interpretativa.*

Resultado: *Nessa análise, demonstra-se que, apesar das intenções de promover diversidade e inclusão, as DCN ainda necessitam ampliar o olhar, que vai para além da hegemonia de saberes eurocêntricos, o que possibilita trabalhar com epistemologias alternativas.*

Conclusão: *Assim, a decolonização do currículo médico visa transformar a formação dos profissionais de saúde, capacitando-os para atuar de maneira crítica e ética em uma sociedade marcada pela diversidade cultural. Por fim, o estudo conclui que, embora as DCN representem um progresso, necessitam de uma reformulação que entenda a realidade local e que não se fundamente em critérios eurocêntricos pautados em estruturas de poder que perpetuam a exclusão e a desigualdade na formação dos médicos.*

Palavras-chave: *Diretrizes Curriculares Nacionais, Educação Médica, Educação Decolonial.*

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INTRODUCTION

Medical education in Brazil is regulated by the 2014 National Curriculum Guidelines (NCG)[1] and characterized by an Eurocentric knowledge framework that uses European guidelines and does not accurately reflect the Brazilian reality, which is deeply marked by cultural diversity. Thus, a critical analysis problematized using the decolonial theory is needed. The guidelines regulating medical education in Brazil are linked to a pedagogical tradition that, although renewed, still exhibits evidence of coloniality, resulting in a misalignment with sociocultural demands. The concept of coloniality extends beyond historical colonialism, encompassing contemporary forms of epistemological, ontological, and psychological domination, and permeates the structural framework of educational practices, including those in the field of medicine.

A qualitative approach was employed to problematize medical education in Brazil based on the 2014 NCG[1] for medical courses and incorporating a bibliographic and documentary review of decolonial theory. The process of tracking and selecting decolonial authors resulted from readings conducted during the study, which were based on the methodological guidelines proposed by Gil[2] (2002). This approach enables an investigation of normative, literary, and theoretical texts within the epistemological framework of the decolonial analysis.

The analysis was complemented by discussing the pedagogical and structural implications of the guidelines and proposing strategies to build a medical curriculum that values epistemological diversity and contributes to the decolonization of knowledge in the health field. Therefore, this study employed an interdisciplinary approach combining education, health, and decolonial studies to achieve a broad and critical understanding of medical education.

METHOD

First, a literature review was conducted encompassing foundational studies on decolonial theory, such as Quijano[3], Mignolo[4] and Walsh et al.[5] and specific contributions to the field of medical education and curricula in general. The literature review aimed to promote the understanding of how coloniality manifests itself in educational practices and how it can be contested and resignified from a decolonial perspective.

Next, a documentary analysis of the 2014 NCG[1] was performed to identify elements that were incorporated and perpetuated in the curricular guidelines to problematize the direction of practices and values that support the coloniality of power, knowledge, and being within the medical education context.

Data were analyzed using a critical interpretation guided by the concepts of coloniality and decoloniality discussed by Quijano[3], Mignolo[4], and Walsh et al.[5] . The interpretation occurred in three main stages: (1) identification of elements present in the curricular guidelines, (2) problematization according to the decolonial theory of medical education at the undergraduate level, and (3) proposal of curricular alternatives that promote inclusive and plural medical education aligned with the principles of a decolonial pedagogy.

DECOLONIAL THEORETICAL-METHODOLOGICAL FRAMEWORK

According to Quijano[3] and Mignolo[4], coloniality extends beyond overt power relations and subtle cultural and epistemological impositions governing what is considered valid knowledge. In the medical education context, the imposition manifests itself in the centrality of Eurocentric knowledge and marginalization of original, African, and popular epistemologies, which, despite their broad potential, are rarely recognized or valued in the official curriculum. Thus, the Brazilian medical curriculum tends to reproduce practices that may be understood as an extension of the colonial project, which, under a modern guise, continues to perpetuate the supremacy of a hegemonic knowledge that devalues or fails to recognize other forms of knowledge.

Similarly, Mometti *et al.*[6] describes how coloniality permeates the educational curriculum by promoting a process of colonization, previously limited to the geographical and political spheres, that is now present in the field of knowledge and subjectivity. These conditioning factors in the interpretation of NCG[1] by medical practitioners working in medical education favor the reproduction of colonial rationality, which, instead of promoting diversity and inclusion, as established by NCG[1], reinforces the hierarchy of knowledge and epistemological exclusion.

Therefore, when considering the decolonial theory as a critical analysis to problematize medical education in Brazil, it is necessary to explore the pedagogical and structural implications of the curriculum in the medical education context. Walsh *et al.*[5] consider that decoloniality is not limited to criticism and propose new perspectives that challenge the dominant Western rationality. Thus, this study aimed to problematize the rationality of medical education based on current guidelines and propose alternatives that enable a plural and emancipatory education that recognizes and values the multiplicity of epistemologies present in Brazil.

The proposed analysis aims to problematize the coloniality that underlies medical education and indicate how the colonized interpretation of the 2014 NCG[1] can, consciously or not, reinforce exclusion and subjugation. Thus, decolonial theory functions as the theoretical instrument that guides

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the investigation, promotes a challenging critique of the established structures, and problematizes medical education based on the needs and realities of the country, especially in the context of public health.

DECOLONIAL CRITIQUE OF THE 2014 NCG FOR THE UNDERGRADUATE MEDICAL COURSE

Article 3 of the Resolution establishes that a graduate in Medicine must act with social responsibility and commitment to the defense of citizenship, and reinforces that social determination of the health-disease process drives this action.

> *Article 3. The graduate in Medicine will have general,* ***humanistic, critical, reflective, and ethical education****, with the capacity to act in different levels of healthcare with actions to promote, prevent, recover, and rehabilitate health* ***at individual and collective levels, with social responsibility and commitment to the defense of citizenship, human dignity, and integral health of the human being,*** *and always having the* ***social determination*** *of the health-disease process as transversal element in their practice[1] (bold added by the authors).*

As noted in article 3, the NCG[1] recognizes biological, ethnic, and gender diversity as fundamental to the field of medical education. However, it is essential to question to what extent the appreciation of diversity extends beyond the discursive plane to effectively confront the power structures that perpetuate inequalities in medical practice. In this sense, we corroborate the concept of coloniality of power proposed by Quijano[3], which describes coloniality as not only a question of political or economic domination, but also of control over knowledge and subjectivities.

An example of this problematization can be found in Section I of article 5, which discusses health care.

> *Article 5. In healthcare, the undergraduate student will be trained to always consider the dimensions of biological, subjective, ethnic-racial, gender, sexual orientation, socioeconomic, political, environmental, cultural, ethical diversity, and other* ***aspects that involve the spectrum of human diversity*** *and make each person or each social group unique[1] (bold added by the authors).*

Although the guidelines propose comprehensive and humanized care and offer an interdisciplinary vision of medical care, they do not guarantee the problematization of the hierarchies of knowledge that persist in the field of medicine. As Sathler and Oliveira[7] discussed in their experience report on decolonial practices in health, medical science remains based on the Eurocentric logic, in which traditional knowledge (e.g., Afro-Indigenous-Brazilian knowledge) is often marginalized in favor of scientifically validated biomedical knowledge. This is a process of exclusion that starts from one of the most subtle forms of the coloniality of knowledge, in which medical practice perpetuates the invisibility of other epistemologies, even when adopting a discourse of inclusion and diversity, as observed in item X of article 5: "X - Promotion of equity in adequate and efficient care for people with disabilities, understanding the different ways and specificities of becoming ill"[1].

The concept of equity in care is interrelated with the decolonial criticism, as it emphasizes the need to treat inequalities with equity and respect the vulnerability of social groups. However, according to Mignolo[4], equity may become an empty discourse that perpetuates the hegemony of a knowledge considered superior if not accompanied by a genuine decolonization of knowledge and practices. Therefore, the promotion of equity in care needs to be discussed so that the NCG[1] may benefit from the broad integration of the epistemologies from the global South, as advocated by Santos and Menezes[8], and ensure that health practices truly value the traditional and modern scientific knowledge.

Thus, to respond to the current global colonial and capitalist demand, the course curriculum is conceived based on Eurocentric knowledge, whose specific worldview is universalized[9]. Specifically in Medicine, the rethinking of the medical curriculum began in 2002 and was influenced by changes and knowledge from American, Canadian, and European countries.

> *The primary objective of the program [about PROMED] is to adapt the training of medical practitioners to the current reality of the Brazilian health system, as the curriculum of medical schools has remained largely unchanged over the last 30 years. Medical schools* ***in Europe, Canada, and the United States of America*** *are undergoing this process of change[10] (bold added by the authors).*

This phenomenon is described by Santos et al.[8] as epistemicide and comprises "[...] the elimination of local knowledge promoted by foreign knowledge"(p.208). This educational model presupposes

> *a violent epistemic and cultural asepsis of society. The other is instituted as the anti-model that does not have the conditions to be, produce, and live civilized without the help (favor) of the one who is. The other lives in a state of borrowing, of not being, and not having, being only able to recognize himself as the non-being and obey the one who is[11](p.206).*

These tensions between the discourse of inclusion and institutional practice converge in the relevance of the decolonial theory for analyzing the NCG[1]. As emphasized by

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Santos[12], appreciating human diversity is an important step; however, this diversity must transcend the abstract concept and requires the materialization of concrete actions that question its epistemic hierarchies. The foundation of these hierarchical structures shapes the field of health and legitimizes certain types of knowledge and practices to the detriment of others.

Section II of the NCG[1] focuses on health management and emphasizes the importance of medical education as an agent, not only clinical but also as a manager within the health system. Article 6 states the following:

> *In Health Management, the undergraduation in medicine aims to train doctors capable of understanding the principles, guidelines, and policies of the health system and participating in management and administration actions to promote the well-being of the community*[1].

Article 6 emphasizes that medical training must enable professionals to understand and act on health principles, guidelines, and policies, actively participating in the promotion of community well-being. The expanded vision of the role of the medical practitioner requires an education that extends beyond traditional clinical practice, integrating aspects of management, leadership, and communication. About care management, the section I states:

> *I - Care Management, using knowledge and devices of all technological densities, to promote the organization of integrated health systems for the formulation and development of individual and collective therapeutic plans*[1].

Section I highlights the importance of medical physicians to use knowledge and technological tools to organize integrated health systems and develop individual and collective therapeutic plans. This approach is reflected in the study by Franco *et al.*[13], in which the centrality of technical skills is discussed, and the importance of the doctor-patient relationship and multidisciplinary work is acknowledged. According to the NCG[1], medical practice should be guided by technical excellence and commitment to the life and comprehensive health of patients, considering their social and cultural particularities.

Regarding the valuation of life, section II defends:

> *II - Valuing Life, with the approach of recurring health problems in primary care, in urgency and emergency, in the promotion of health, and in the prevention of risks and damages, aiming at the improvement of quality of life, morbidity, and mortality indicators, by a generalist, proactive, and problem-solving medical professional*[1].

The NCG[1] proposes that the general medical physician must be decisive, proactive, capable of dealing with the complexities of primary and emergency care, and focused on improving quality of life indicators. Accordingly, Franco *et al.*[13] stated that medical education needs to be effective and technically and socially responsible. Thus, it means being able to make informed decisions based on scientific evidence and actively listen to communities, in agreement with the criticism that medical education is often tied to a technical model that neglects the social complexity of healthcare.

Regarding communication, article 6 of the NCG states the need to incorporate "whenever possible, new information and communication technologies for remote interaction and access to remote databases"[1]. In line with the NCG[1], Franco *et al.*[13] stated that the integration of information and communication technologies is primordial for the practice of medicine in the contemporary context, mainly to facilitate the interaction between health professionals and patients, which is seen as imperative in the training of modern medical practitioners. However, this technological communication should be mediated by interpersonal skills and a profound understanding of the needs of patients [13].

To facilitate the interaction via information and communication technologies, the role of health leaders is also necessary for the NCG[1].

> *V - Leadership exercised in the* ***horizontality of interpersonal relationships*** *that involve commitment, responsibility, empathy, and the ability to make decisions,* ***communicate, and perform actions effectively and efficiently****, mediated by interaction, participation, and dialogue focused on the well-being of the community*[1] *(bold added by the authors).*

The application of horizontal leadership based on community interaction and participation, as stipulated in the NCG, reflects a necessary change in medical education. According to Franco *et al.*[13], competency-based training should include leadership, management, and teamwork skills, which are essential for medical practice in an increasingly complex and interconnected health system.

The sole paragraph of article 8 defines competence as the ability to mobilize knowledge, skills, and attitudes positively in different contexts, conferring a training that is technical, integrated, and contextualized[1]. Franco *et al.*[13] criticized traditional technical training by indicating that it does not adequately prepare professionals to deal with the social and cultural complexities of the work environment.

In the healthcare field, specifically in the identification of health needs and development of therapeutic plans, medical practitioners are required to consider psychological, cultural, and contextual factors (e.g., life history and cultural practices),

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reflecting a comprehensive view of health. Franco *et al.*[13] also emphasize that medical practice must incorporate the particularities of each patient, avoiding a universalist approach that is insensitive to diversity, to create bonds with patients and promote autonomy in care, as emphasized in article 12.

However, the requirement that biological, psychological, socioeconomic, and cultural aspects must be considered during the clinical interview, including healing practices of Afro-Indigenous-Brazilian origin, highlights the importance of a decolonial perspective in medical education, which recognizes and emphasizes traditional and popular knowledge. The monopoly of knowledge has led to epistemic colonization, which persists in the hegemony of modern science and challenges the different ways of thinking that interact with modern science to rescue the knowledge and practices of social groups subjugated by colonialism and capitalism[8,14.]

The critical perspective of Western medicine, which often devalues these forms of knowledge, is discussed by Franco *et al.*[13]. In this case, the importance of a medical education that enables the integration of different forms of knowledge into clinical practice is highlighted.

Section III on health education discusses the co-responsibility of undergraduates in their ongoing education and the education of future generations, reinforcing the importance of intellectual autonomy and social responsibility in medical practice. According to Santos[12], medical education should prepare students to learn and promote scientific curiosity and critical thinking from the earliest years of training. Autonomous and interprofessional learning is part of what medical practitioners must develop to sustain pace with innovations in medicine and actively contribute to health practices.

The formulation of diagnostic hypotheses and promotion of diagnostic investigations, as discussed in article 13, highlight the need for medical practice based on scientific evidence while also considering the social and cultural contexts of the patient, as observed in item b of article 13: discussion of the plan, its implications and prognosis according to the best *scientific evidence*, the *cultural practices of care*, and healing of the person under care, and the individual and collective needs[1] (bold added by the authors).

In this sense, we agree with Franco *et al.*[13], who defended the notion that medical practice should be informed by the critical analysis of evidence and always consider the particularities of the patient and local context.

Subsection II of the NCG[1] addresses attention to collective health needs. According to Oliveira[15], bioethics is an important factor in the development of guidelines and an integrating axis that permeates all medical training: "bioethics is legitimized in the National Curriculum Guidelines. The training apparatus must ensure that bioethics is consolidated in academia"[15](p.s308).

The emphasis on investigating collective health problems, as described in articles 14 and 15 of the NCG[1], is needed to understand that ethics must consider the social, cultural, and economic dimensions of population groups.

> *I - access and use of secondary data or information that includes the* ***political, cultural, institutional, socioeconomic, environmental, and relationship discrimination context, movements, and values of populations*** *in their territory to expand the explanation of causes and effects based on social determination in the health-disease process, as well as its confrontation[1] (bold added by the authors).*

The recognition of contexts of vulnerability and the articulation between epidemiological data and living conditions of communities is fundamental for promoting comprehensive and equitable health, as suggested by Oliveira[15]. This reinforces the social relevance of academic action in medical education to consolidate bioethics as a movement for social transformation and the promotion of citizenship within the context of public health.

The role of the medical practitioner as a manager and active participant in the development of public health intervention projects, as outlined in the article 15, exemplifies the practical application of bioethical principles. Engagement in the formulation of collective health diagnoses and the implementation of intervention plans requires ethical commitment. Oliveira[15] suggests that such a commitment is essential for medical practice to transcend technical expertise and embrace social responsibility. Therefore, medical education must allow professionals to act ethically, promote the well-being of communities, and respect the diversity and singularities of each social group.

This reinforces the idea that integrating bioethics into NCG[1] extends beyond theoretical recommendations and constitutes a practical need to ensure that Brazilian health professionals are prepared to face the challenges of the health system with a critical perspective.

Section III addresses the health education area and three key actions: identifying individual and collective learning needs, promoting knowledge construction and socialization, and fostering scientific and critical thinking and supporting the production of new knowledge. These central actions for the education of health professionals aim to master technical-scientific knowledge and prepare them to act reflexively within the health system. According to Kussakawa et al.[16], curricular reforms, such as those established by the NCG[1], are disputed territories shaped by different forces, including political, economic, cultural, and technological.

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The key action of identifying individual and collective learning needs, outlined in article 20 of the NCG[1], emphasizes the importance of an educational process tailored to the needs of individuals and social groups. Kussakawa et al.[16] presented a critical dialogic perspective on the rigidity of previous curricular structures and observed the transition to a flexible model responsive to the contextual needs of the students and society.

Furthermore, the promotion of knowledge construction and socialization, as set out in article 21, emphasizes an open and interactive approach within the educational process, in which the construction of knowledge is a collective effort aligned with the "work-based learning methodology" described by the authors[16]. This approach values practice over theory and promotes the integration of different knowledge and practices in real-world contexts.

The promotion of scientific and critical thinking and support to produce new knowledge, according to article 22, is essential for the development of innovative medical practice, which, according to Kussakawa et al.[16], leads professionals to deal with the complexities and uncertainties of the health-disease process in different social contexts.

Kussakawa et al.[16] also state that "practice should be understood as an essential part of the educational process, in which learning occurs in an integrated and contextualized way that promotes autonomy and critical thinking." Thus, medical education should not be limited to the transmission of theoretical knowledge but rather promote the practical application and critical reflection as an integral part of medical education.

Last, chapter III of the NCG[1] establishes the foundation for the curricular organization and pedagogical project of these courses, with the aim of training professionals to work comprehensively and competently in the Brazilian health system, especially in the context of the Unified Health System (SUS). Articles 23 and 41 outline the fundamental guidelines for developing a curriculum that addresses the complexity of the health-disease process and integrates technical, scientific, and humanistic knowledge. For instance, article 23 emphasizes the importance of a curriculum that encompasses the biological bases and social determinants of health.

The introduction of cross-cutting themes into the curriculum, such as human rights, environmental education, and the history of Afro-Indigenous-Brazilian culture (Article 23, section VII), is part of an effort to integrate a broader and inclusive perspective into medical education. In practice, this notion aligns with contemporary demands for medical education that trains competent technicians and professionals aware of their social role. Kussakawa et al.[16] emphasized that "the incorporation of cross-cutting themes into the curriculum is essential for the training of practitioners capable of understanding and acting in diverse social and cultural contexts in which they perform their activities."

The mandatory internship, as outlined in article 24, must comprise 30% of the internship workload in the areas of primary care and emergency services, reinforcing the importance of in-service training, particularly within the scope of the SUS, and highlighting the need for practitioners to understand and engage with the realities of the Brazilian public health system. The practical immersion in the SUS is also a strategy to ensure that graduates are technically and socially prepared for the demands of public health in Brazil.

Article 16 defines the pedagogical project centered on the student as the subject of learning and reinforces an active and reflective pedagogy. In this sense, Libâneo[17] clarified that the emphasis on "doing" and "learning by doing" ultimately subordinates the mastery of concepts to the focus on operational skills, reducing its contribution to the development of reflective capacities and intellectual autonomy of the students.

Regarding the scope of the influence of the New School movement and its methodologies in the medical field, few studies have performed a critical problematization. Libâneo[17] explained that Dewey influenced Paulo Freire in the formulation of his proposal for awareness-raising education, characterized by a dialogical and participatory approach that promotes the problematization of reality and intervention in its transformation[18,19]. This leads him to be one of the main proponents of active methodologies, such as the Problematization Methodology[20,21]. According to Libâneo[17],

> *For a productive discussion on active methodologies, it is necessary to start with the question, "What are schools for?" In other words, it is necessary to start with the formulation or proposition of educational purposes, in which political-ideological and pedagogical assumptions lie behind the question of teaching methodologies; that is, didactics and teaching methodologies are subordinate to educational purposes(p.111)*

Article 29 emphasizes the need for curricular integration and interdisciplinarity, encompassing the biological, psychological, ethnic-racial, socioeconomic, cultural, environmental, and educational dimensions. A central aspect raised by Kussakawa et al.[16] is that "interdisciplinarity is essential for the training of health professionals capable of understanding and intervening in the complex relationships that constitute the health-disease process". This integration tends to train practitioners to work collaboratively in multidisciplinary teams, a crucial skill in the current health context.

Article 30 addresses the monitoring and evaluation of the NCG[1] and underscores the importance of an ongoing

process of monitoring and adjustment to ensure that the implementation of these guidelines aligns with the needs and realities of the health field. Constant evaluation and adaptation of the curriculum are strategies to sustain the relevance and effectiveness of medical education in the face of rapid social and technological changes.

Last, article 36 establishes a biannual mandatory assessment of medical students to ensure that the training is aligned with the objectives of the NCG[1] and their theoretical knowledge, practical skills, and professional attitudes are assessed. Thus, a continuous assessment ensures the quality of medical education and competence of the graduates.

FINAL CONSIDERATIONS

The 2014 NCG[1] is a milestone in the Brazilian medical education and proposes a distinct practice considering the biological aspects and social determinants of health. However, throughout the critical analysis of these guidelines according to the decolonial theory, it is clear that, despite advanced in terms of inclusion and diversity, the NCG[1] still has marks of coloniality, as evidenced by the Eurocentric knowledge and marginalization of alternative epistemologies.

Although the guidelines explicitly intend to promote a humanistic and critical medical education, they still operate within a perpetuating paradigm of hegemony of Western scientific knowledge, often to the detriment of traditional and popular knowledge. This highlights the need for a curricular reform that surpasses the superficial inclusion of cross-cutting themes and truly integrates diverse forms of knowledge into the educational process.

Proposals to value diversity, equity in care, and interdisciplinary integration are important advances. However, as discussed by decolonial theorists, these initiatives need to be accompanied by a true decolonization of knowledge and educational practices to train practitioners capable of acting effectively and ethically in a diverse and unequal social context, such as Brazil.

According to the NCG[1], the insistence on active methodologies and continuous assessment of students leads to an education in which knowledge and skill acquisition remains limited to the empirical experience and does not favor the assimilation of action principles focused on theoretical and conceptual knowledge[17]. Therefore, these methodologies must be applied to promote the intellectual autonomy and critical thinking of students; thus, preventing them from becoming only instruments of conformity to existing standards.

Therefore, although the 2014 NCG[1] represents an advance in the medical education aligned with contemporary demands, it still requires reformulations to rethink the power and knowledge structures perpetuating exclusion and inequality.

AUTHORS' CONTRIBUTION

Lucas Vieira: project administration, conceptualization, investigation, writing - original draft, writing - review and editing, methodology, supervision, and validation. Inauã Weirich Ribeiro: formal analysis, conceptualization, data curation, writing - original draft, and writing - review and editing, investigation, methodology, supervision, and validation. Etyany Lays Mariano da Costa: writing - original draft. Ana Caroline de Moraes Oliveira: writing - original draft and writing - review and editing. Leide da Conceição Sanches: project administration, formal analysis, conceptualization, writing - original draft, and writing - review and editing, investigation, methodology, and supervision.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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DATA AVAILABILITY

Research data is available in the body of the manuscript.

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